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CLINICS.

CLINICAL LECTURE.

Clinical Lecture on Cataract, with Reference to Improved Methods of Diagnosis and Treatment.—Delivered at St. Mary's Hospital. By ERNEST HART, Esq., Ophthalmic Surgeon to St. Mary's Hospital and Lecturer on Ophthalmic Surgery in the medical school.

GENTLEMEN: The patients who happen to be under treatment in the Ophthalmic department to-day illustrate some points in the diagnosis and operative treatment of cataract to which I would willingly direct your observation as matters of practical importance.

We have here present, as out-patients, three persons whom we have found to be affected with incipient cataract, and one who was believed to be so, but most certainly is not. We have in the house three patients, on whom I have this week operated for cataract, each by different procedures. These cataractous persons are all in different positions as respects their past and present visual powers, and especially as regards their prospect of restoration to good sight, the treatment or operation indicated, and the prognosis which we can conscientiously establish for them. Hence you may notice that in each of these six cases, although all examples of cataract, there are circumstances which induce me to differentiate their symptoms, to modify the prognosis, and to vary the manner of dealing with them. In all the problem is the same: given a patient with cataract, how to restore the sight; but its solution should not be nearly so uniform as may be conceived from that view of the case, or as you may gather from any merely classical and systematic statement. You will not arrive at results so satisfactory as science and humanity may fairly demand from you, unless you attend to all the minute particulars of each case, and modify your practice and conclusions in harmony with them. No amount

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of care is too great to enable you to arrive at a complete success, for it may be asserted with ample certainty that the difference between moderately good and extremely good results, in the treatment of cataract, will depend upon a strict attention to details, and the incorporation of the latest results of ophthalmic research.

I take it for granted that you are acquainted with some of the ordinary facts concerning the origin, appearance, and treatment of cataract, and I will use these cases to draw your attention to the differential circumstances which have in each case modified my prognosis and induced me to vary the procedure.

Let us take first of all the old man, with double, amber-coloured, hard cataracts, whom his wife has led here, and who has been in attendance for some weeks. The first glance at him, as he was led into the room, revealed the probable nature of the affection. Advancing slowly, and with an evident apprehension of striking against large objects; the eyeballs not fixed in a stony stare, but directed vainly in various directions, and obviously having some perception of the light from the window; the pupils acting equally; the pupillary space occupied by yellow opaque lenses; the diagnosis might be made *un coup d'œil*. A few questions satisfy us further. His general health is good; *he has never been short-sighted;* pressure produces the *phosphenes;* the retina even, through the dense crystalline, or rather, perhaps, around it, responds also to some extent to the photometric test of a powerful artificial light. We can have his urine tested, and there is little doubt that neither sugar nor albumen is present; he does not suffer under the rheumatico-gouty diathesis; he is not marasmic. Here, then, is a simple and favourable case of senile cataract, of which the prognosis is so far good. Nevertheless I hesitate to admit him for operation at present, because he has slightly granular lids, and the right cornea, by its faint and recent opalescence, indicates the existing irritation which they excite; because, moreover, there is in both eyes displacement of the puncta lachrymalia and consequent epiphora, "the watery eye." These circumstances would be sufficient to cause an undue irritation of the flap and an accumulation of secretions after the operation, which might compromise its success. I shall apply myself to remedying both before extracting the cataracts. I am now treating the lids by pencilling their conjunctival surface with a combination in stick of one part of nitrate of silver with two of nitrate of potash, being careful to avail myself of the services of this combination in dosing and limiting the alterative action of the nitrate of silver, and also to neutralize any superfluity by immediately washing over the surface with a solution of common salt and water, which converts any excess of nitrate into the harmless chloride. The epiphora remedied by dilatation, and, perhaps, division of the canaliculs, he will be ready for operation, and by removing these accessory causes of possible mischance, his case will have become so favourable that such a prognosis may be made with considerable confidence.

Now as to the next case—the pallid and somewhat debilitated female of fifty-two years of age, whom we have examined ophthalmoscopically. Note first the leading points of her history. Her sight has never been very good, she says; since twenty she has been short-sighted, and of late years this defect has considerably increased. She has had a great deal of trouble. Has worked at the needle. She is spare and pale, with thin skin. Has never had any serious illness or uterine hemorrhages. She can barely read No. 30, Giraud Teulon's type, with the right eye and at seven feet distance, and the left eye is in a somewhat worse case still. She can read no type smaller than No. XX. Examined by sunlight, the eyeballs are seen to be flattened rather than prominent, and to recede in the orbits. The pupils act well, and contract closely under a strong or concentrated light (using a lens of short focus), which is moreover unpleasant to the patient. No trace of opacity can be discovered by this method of examination. The pupil being dilated with a small disk of the *atropized gelatine*, prepared under my directions by Messrs. Savory and Moore, and containing the 100,000th of a grain of atropine, we have seen with the aid of the demonstrating ophthalmoscope the following appearances. Lowering the light and disposing the collecting lens to bring the surface of the crystalline into view, we have observed in its substance dark streaks, pyramidal in shape, radiating from the circumference (not very regularly)

towards the centre of the lens. These dark streaks are so many places at which the crystalline stops the light, which should normally, and elsewhere does, pass through it to strike upon the retina and choroid, and returning from the choroid reproduce the image of its scarlet surface. They are so many opacities of the lens—commencing points of what will be a complete cataract. I lowered the light because a feeble illumination is by far the most useful in this investigation. This is a practical point necessary to be observed in the investigation, and the non-observance of it explains why some writers have expressed their disappointment at not finding ophthalmoscopy so useful as they hoped in the detection of incipient cataract. The word "useful" is, however, feeble to express its value when applied with precaution: it is infallible, and therefore inestimable. Dilate the pupil fully with atropine; and for this purpose a very minute dose suffices—100,000th of a grain in *atropized gelatine*—better than the old dose of a 240th, which is contained in each drop of the collyria of ophthalmic formularies. Lower the light, and adapt your collecting lens to focus the crystalline, and not an opaque streak or fibre or dot will escape your notice. You will discover the first traces where they were unsuspected, and where by no other means can they be detected. You will pronounce with certainty in every case whether there is or is not cataract of the most incipient stage. No chance of confounding cataract with amaurosis, or opacities of the vitreous with disorders of the lens. No need of temporizing or doubting, or of dwelling in platitudes. You can assure yourself of the nature of the case so far. Now turn up the light, and adjust the apparatus so as to focus the retina and the fundus of the eyeball. What do we see there? Why, since the central portion of the lens is but very slightly if at all affected by the advancing cortical and circumferential degeneration, we have obtained in this case valuable information to guide us in our prognosis. We see the cream-coloured optic papilla with its brilliant retinal veins, the transparent retina, and the rich background of scarlet-carpety choroid, deformed by evidences of slow, chronic, and progressive pathologic change of a very serious character. The papilla is surrounded by a band of white, instead of the scarlet choroid, reaching quite up to its borders. This is the white sclerotic which we see, because the choroid is here atrophied and deprived of its pigment. It completely surrounds the papilla; it is broad and irregular in shape; its boundary edge, where it joins the choroid, is cut into sharp angular processes, which are fringed heavily with black pigment. You know that these are among the ophthalmoscopic signs of pouching of the posterior section of the sclerotic; posterior staphyloma; a pathological condition which has become familiar to you, in association, not with that form of myopia which is due to the comparatively innocuous excess of refraction in the dioptric media of the eye, but in that insidious and mischievous kind of short-sightedness which is produced by the elongation of the antero-posterior axis of the eyeball from such retrocession of the sclerotic as we have here. This, as I said, is connected with choroidal disease; the white band around the papilla indicates atrophy of the choroid with sclerotic shining through it. We can see near the "yellow spot" another place at which there is a black patch, showing that here also the choroid is diseased, and pigment is amassed. Probably the cataract is secondary to the choroidal disease, of which the advancing short sight was an important symptom which she has long neglected.

Here, then, we read many things which it greatly concerns us to know, but which we could not learn except from the ophthalmoscopic observation of the eye, or if we had only seen the patient at a later stage, when the general and increased opacity of the lens will have hidden the fundus from our view. The cataract is one in a chain of pathological changes; the alteration in the lens is subsequent and consecutive to a series of morbid processes affecting the nutrition of the eye, and probably commencing in the choroidal coat. This patient can never be restored to perfect sight, for the eye has no longer the elements of perfect vision. In the case of the old man, we may presume with little doubt that he will recover vision of even the smallest objects; and his will probably be one of those satisfactory cases in which we have the pleasure of seeing our patients, after undergoing extraction, and being provided with proper glasses "read the small print

of *The Times*,"—the popular test of excellent sight in old age. Not so in this patient; we can only anticipate for her recovery of vision to a useful but limited extent. The extent to which her visual power is affected is already out of proportion to the amount of opacity, which is mainly circumferential, and we shall not ultimately be able, by the extraction of the lens, to restore her all that she misses, although after a course of nutritive and tonic treatment she will greatly improve, and will have useful sight after operation.

In the third case we see a patient—a female aged fifty—who complains of pain and fulness in the eyes, of occasional haloes when she looks at lights in the evening, and of mistiness of vision. The eyeball is naturally prominent, and the thyroid gland full; and at a cursory glance the symptoms might have been assumed to be "functional," and so passed over with a slight medical treatment. On examining her acuteness of vision, however, by test-types, we find that it is defective to the extent of one-third; and, resorting again to ophthalmoscopy, we all see, what *primâ facie* there did not appear to be any reason to suspect, that the lens is undergoing the form of degeneration which leads to cataract, and the whole circumference is occupied by little spicules of opaque substance, arranged with elegant regularity around the border, their apices pointing towards the centre, but none of them shooting into the central part at present. The choroid and retina do not present any apparent changes, and have the appearance which is pronounced healthy, although probably a subtle affection of the choroidal circulation exists in connection with the altered nutrition of the lens. To the naked eye there was here no appearance whatever of cataract, and, except for the kind of investigation which we have made, we should have remained altogether in the dark as to its existence. It would seem that in the process of degeneration which a lens passes through in becoming opaque, it swells, and to the enlargement in bulk may be traced the uneasiness, the subjective creation of haloes and sparks, and the other symptoms simulating what has been generically styled incipient "amaurosis"—a name hiding more different conditions than would one title including all the diseases of the chest. The investigation of the patient's constitutional condition is in all respects favourable to her. Here again, then, the chart is clear, and we may expect a favourable progress. We prescribe for her a refreshing lotion, douches with pulverized water, repose for the eyes, neutralization of yellow artificial light, an occasional treatment with an aperient chalybeate,[1] and the local use of iodide of potassium. A word as to the latter. I have no positive data for urging its use. I have not even formed any decided impressions. But there is a certain amount of chemical and of clinical evidence in its favour, as an agent capable of retarding the opaque change of the lens, and of removing its opacity. Another time I will lay this before you, *à propos* of cases of traumatic cataract; but I here only refer to it as an agent which may be rationally used in this relation. So used, it passes beyond question into the anterior chamber of the eye, traversing the cornea endosmotically; this you can prove for yourselves experimentally. By applying the salt in the dry form—that is, by introducing either morsels of paper, like the atropine papers of Mr. Streatfeild, or these minute disks of gelatine which I have had prepared—much more will enter the chamber than if only a drop of a solution were used: for the solution passes quickly away with the tears; while in the case of the dry application, the salt, dissolving out slowly, has a greater opportunity of penetrating the cornea endosmotically. The history of ophthalmoscopy embraces as yet no long series of years: and the *natural history* of cataract, observed ophthalmoscopically from its very first beginning, remains to be fully written: it is a work of great clinical interest and importance, and for which every month brings fresh material. But we must wait and watch through their slow course a long series of cases before we can see what is its ordinary rate of progress, irrespective of treatment; and what the influence of such local medication, before we can arrive at any trustworthy conclusion. But I have cases under observation where I have been using the iodide of potassium during the last three years, and where no perceptible progress has occurred

[1] In the following formula: Sulphate of iron, half a drachm; sulphate of magnesia, half an ounce; dilute sulphuric acid, half a drachm; syrup, half an ounce; water up to eight ounces. To take an ounce night and morning.

in the spread of the opacity. Now take note that I do not say this is because of the topical use of iodide of potassium: for it remains to know in how many cases cataract observed in its early stages may be arrested by natural causes, or retarded by constitutional means and general hygiene of the body and of the eyes; and what is its rate of advance under varying circumstances. It is sometimes slow; but now that we can determine its existence from the first, we shall be able always to watch it, and to determine in time its natural history, and our power over its development, with precision.

The fourth case we need not dwell upon. It was sent up to us as "a case of cataract for extraction," having been so considered by the practitioner who had inspected it. We have seen, however, that it is a case in which the lens, although muddy and discoloured, is not opaque or cataractous, but the retina is detached and floating in the lower and outer part of the posterior pole of the right eye, and still more so in the left. The other changes it would be apart from the purpose to dwell upon: it is a case of choroido-retinal degeneration, with detachment. With a little more attention it would not have been diagnosed as cataract, even without the use of the ophthalmoscope, but would have been set down as "amaurosis" perhaps; for the use of a lens with sun or candle light would have shown that the crystalline is not opaque. Supposing that this care had not been exercised at all, and the lens had been extracted, this case would have added unduly to the list of failures of the operation of extraction: sight would not have been restored by that proceeding.

Reviewing now these cases and the remarks which they have suggested, I would summarily point out to you the following conclusions which they illustrate:—

1st. That it is possible to determine with certainty, in every case, whether cataract, incipient or well developed, is present; of what kind is that opacity; in what part of the lens situate: even when beyond the reach of the naked-eye or daylight inspection.

2d. That in the early stage we can form with accuracy a diagnosis and prognosis founded upon the actual state of the retina, choroid, optic papilla, and humours. This will modify our treatment, and may cause us to vary the mode of operation.

3d. That considerable or rapidly increasing shortsightedness may be considered as of ill-omen when, the cataract being fully formed, inspection of the fundus is no longer possible.

4th. That the utility of topical medication in the early stage, especially by the use of medicated gelatine (impregnated with iodide of potassium, &c.), is a therapeutic means deserving of attention.

5th. That the diathesis or constitution of the patient must be investigated: marasmic patients may be strengthened, diabetic patients dieted, and rheumatic and gouty patients doctored; and that by modification in these respects and in the operation success may be secured in the most unpromising examples. For to be forewarned is to be forearmed.

6th. That the physical investigation of every patient suspected to be incipiently cataractous should be complete, including the test of acuity and range of vision; the direct examination by concentrated light with a bi-convex lens obliquely and laterally—ophthalmoscopically; and the production of the phosphenes.

In the above cases you have seen most of these conclusions brought to test practically, and the present state of these eyes and the future promise thus established. The results of operation in the three cases operated on show how this care is ultimately and practically most useful. In one patient I chose linear extraction; in another, simple flap extraction; and in the third, a flap with excision of a portion of the iris: all with good results. I have passed the limits of a clinical lecture, and in the next I will draw your attention to the considerations which governed that choice, and which make it reasonable to believe that the variation has conduced in each case to success. I do not wish you to think ophthalmic surgery peculiarly complicated or difficult; but it requires peculiar care and patient clinical insight.—*Lancet*, April 9, 1864.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Bark of Fraxinus Nigra as an Antiperiodic.—Dr. D. W. C. Denny, of Albion, Ind., extols (*Cincinnati Lancet and Observer*, April, 1864) the efficacy of a strong

decoction of the bark of Fraxinus nigra in the treatment of intermittents. He prepares this decoction by divesting the bark of its outer covering, then stripping it from the tree, cutting it in small pieces, which he places in a small iron kettle, until nearly full, to which is added rain water sufficient to cover. The bottle is then placed over a good fire, and allowed to boil until half evaporated. The liquor is then strained through a coarse cloth, returned to the vessel and allowed to slowly evaporate to the consistence of molasses. Dr. D. commences ten hours previous to the expected paroxysm, and administers a tablespoonful every hour until nine have been given, always adding a full dose of opium or morphia to the last dose.

Dr. D. thinks this decoction may be profitably substituted for quinia, and that the disease is less apt to return after the former has been used than after the latter.

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The American Medical Association and Dr. Morton.—One of the redeeming acts of the American Medical Association at its late session in New York, was the adoption, by a nearly unanimous vote, of the following preamble and resolution offered by Dr. Henry D. Noyes, delegate from the New York Eye Infirmary, and supported by our esteemed and genial friend Dr. Mauran, of Providence, R. I.:—

Whereas, There is now pending in Congress an appropriation donating to Dr. T. G. Morton, of Boston, the sum of $200,000 for his services in connection with the introduction of sulphuric ether as an anæsthetic agent; and

Whereas, The said Dr. Morton, by suits against charitable medical institutions for infringements of an alleged patent covering not only sulphuric ether, but the state of anæsthesia however produced, has placed himself beyond the pale of an honourable profession and of true labourers in the cause of science and humanity;

Resolved, That the American Medical Association enter their protest against any appropriation to the said Dr. Morton, because of his unworthy conduct, also because of his unwarrantable assumption of a patentable right to anæsthesia, and further, because private beneficence in Boston, New York, Philadelphia, and other places, has already sufficiently rewarded him for any claims which he may justly urge.

Resolved, That a copy of these resolutions be sent to the Chairman of the Committee of Ways and Means of the House of Representatives at Washington.

Adopted.

—

Medical Society of the State of Pennsylvania.—This society held its fifteenth annual meeting at the hall of the College of Physicians in Philadelphia on the 15th and 16th of June.

Several interesting reports from country medical societies were read, and also one from Dr. John Bell, on Physical Education of the Young, also a paper by Dr. Hiram Corson, of Montgomery County, on "Ice and Ice-water in Disease."

Dr. J. D. Ross, of Blair, was elected president for the ensuing year, and the society adjourned to meet next year at Altoona on the second Wednesday of June.

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Harvard University.—The corporation of this school has established a professorship of the Physiology and Pathology of the Nervous System, and Dr. E. Brown-Séquard has been elected to fill the chair.

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Long Island College Hospital.—At the fifth annual commencement of this institution on the 1st of July, the degree of M. D. was conferred on 37 candidates.

FOREIGN INTELLIGENCE.

Death from Chloroform in King's College Hospital.—On Friday, June 24, an inquest was held at King's College Hospital on the body of Mrs. E. Ruth, aged 29 years, who died under the following circumstances: Chloroform had been administered to her in the hospital with a view to the removal of a tumour in the urethra, but she died from the effects of the vapour.—*Med. Times and Gaz.*, July 2, 1864.

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Sudden Death from Pulmonary Emboli in Contusions and Fractures.—Dr. Azan, of Bordeaux, concludes, a paper read before the Academy of Medicine with the following conclusions: 1. Fractures and contusions may give rise to sudden death through pulmonary embolism. 2. The emboli originate in a thrombosis of the veins of the injured region, itself due to the absorption

of effused blood. 3. These thromboses, or the phlebites which precede them, are generally latent, and are of more common occurrence than would at first sight be supposed. 4. The exploration by means of the finger of the track of the veins can alone demonstrate their existence. 5. Sudden pulmonary accidents, as dyspnœa, hæmoptysis, precordial pain, syncope, etc., indications of the presence of an embolic coagulum of varying size, may direct the attention of the surgeon to the phlebitis. 6. In venous thrombosis the coagula are more or less adherent, and the plasticity of the blood is proportionate to the solidity of the adhesions. Fractures compelling repose are unfavourable to plasticity. 7. The various movements of the parts, and the application of the apparatus, may favour the detachment of the coagula. 8. The surgeon should investigate whether, from the fifteenth day, in cases of fracture and contusion, latent phlebitis does not exist. 9. If this is discovered, rest, antiphlogistics, and an alkaline treatment are indicated.—*Ibid.*

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Application of Dialysis for the Conversion of Salt into Fresh Meat.—Mr. Whitelaw, in a communication to the *Chemical News*, gives an account of *An Application of Dialysis for the Conversion of Salt Meat into Fresh.* The salt meat is placed in a dyalytic bag made of untanned skin or other suitable material, is filled nearly full of brine from the beef barrel. The dialyser is then placed in sea water, and the process allowed to go on for several days until the meat and brine are sufficiently fresh for use, or until the brine in the bag is within one or two degrees (Twadde's hydrometer) of the sea water. In this way the brine becomes free from salt, and the beef, which by the action of the salt has been contracted, gives its salt to the brine in the bag, and so the process goes on, the beef expanding like a sponge, and gradually taking up a greater part of the natural juices that it had previously lost in the salting process. In this way no loss of juice is sustained by steeping, and the brine left in the bag after a night's dialysis in fresh water may be used for soup.—*Dublin Med. Press*, June 22d, 1864.

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Utilization of Brine.—The *Pharmaceutical Journal* for April last contains an abstract of a paper read by Mr. Whitelaw to the Philosophical Society of Glasgow on the Utilization of Brine, in which he proposes to separate, by dialysis, the salt and nitre of brine, leaving the extractive matters which it is known are drawn from the meat in the process of salting. A simple mode of operation consists in filling bladders with the brine and suspending them in vats of water, removing the water about once a-day. The operation is usually completed by the end of the third or fourth day. Two gallons of brine yielded 1 lb. of solid extract, containing the coagulated albumen and colouring matter. For the production of the same directly from meat, something like 20 lbs. of lean beef would be required. He believed that in Glasgow alone over 60,000 gallons of brine were thrown away yearly, equal in soup-producing power to 187 tons of meat without bone. Estimating the meat at 6*d.* per lb., this amounted to a loss of £10,472.—*Med. Times and Gaz.*, June 4, 1864.

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Dialysis.—M. Grandeau, in a recent communication to the Academy of Sciences, gives an account of the experiments which he has made with Mr. Graham's mode of analyzing by dialysis, and states that, aided by this, even the minutest portions of morphine, bromine, or digitaline cannot in future escape the researches of the toxicologist.

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Antiquity of Man.—A very important paper, which has been looked for with great interest for some little time, was read on Thursday night last at the Royal Society by Professor Owen, who has recently secured for the British Museum a most valuable treasure-trove, consisting of a very large collection of fossils, animal and human, from a cave in France, of undoubted authenticity and positively contemporaneous. This great body of evidence bearing on the antiquity of man has been obtained under singular circumstances. The fossils came from the Cave of Bruniquel, in the department of Tarn et Garonne, which, in 1863, was first explored by the proprietor, Vicomte de Lastic St. Jal, who obtained from it numerous specimens, remains of animals; flint implements; bone implements, fashioned and carved by means of the flint knives; and, finally, what the Vicomte believed to be human remains, all imbedded in the *breccia*.

On receiving a letter to this effect, Professor Owen proceeded in January, 1864, to Bruniquel, explored the cavern, observed other human remains *in situ*, and determined amongst the collection of fossil animals the remains of a reindeer and of two kinds of extinct deer, a few remains of red deer, the extinct *Bos primigenius*, and many other species. About 80 per cent. of the beasts killed for food by the primitive inhabitants of the cavern consisted of a large variety of the reindeer.

The Vicomte de Lastic St. Jal had, some months previously, communicated his discovery to his own Government, who had treated his communication with neglect; and it was only after a long delay that the Vicomte resolved on addressing a letter to the British Museum. Prof. Owen seems to have promptly perceived the possibilities which lay beneath such a statement, and after one or two further inquiries started off personally, and at the cost of great fatigue in travelling, visited the spot. After inspecting the cave, he was able to satisfy himself of the value of the discovery, and, immediately returning to England, requested the trustees of the Museum to acquiesce without delay in the addition of this treasure to our national stores.

Meantime, however, a remarkable episode occurred. The visit of Prof. Owen appears to have stimulated the French authorities, and Professors Milne-Edwards and Lartet were despatched on a commission of inspection. They also recognized the value of the discovery: and presently an offer was made from the French Government slightly outbidding that which Prof. Owen had made, under the necessary reserve of approval by the trustees. The Vicomte de Lastic St. Jal honourably adhered, however, to his verbal treaty with the Professor, who telegraphed the assent of the trustees.

Thus this large collection of fossils—some fifteen hundred, many still imbedded in the calcified mould of mud in which they were found beneath the stalagmite—is now deposited in the British Museum; and the history of these specimens is being carefully deciphered by Professor Owen, who will, it is understood, find in them materials for more than one contribution to the history of fossil man. His present communication was confined to an account of the cavern and of the human remains; a calvarium, the back part of a cranium, and the jaws and teeth of adult and young individuals, were specified. The cranial characters were compared with those of the skull from Neander-thal, and that from Engis, valley of the Meuse; also with the crania from the lake dwellings and ancient burial-grounds of Switzerland, described in the "Crania Helvetica" of Rutimeyer and His. The most perfect calvarium from Bruniquel most nearly resembled, in size and shape, a skull from the Pfalbau of Steinberg. It had not the variety of the great development of the region of the frontal sinuses, as in the Batavian skull figured by Blumenbach in "Dec. ultima LXIII.," and in the Neander-thal cranium. Nor were there any characters indicative of an inferior or transitional type. The evidence of the contemporaneity of the human remains with those of the extinct and other animals was conclusive. Thus the failure of the jaw-bone of Moulin-Quignon is more than amply compensated.

The splendid series of specimens acquired by Professor Owen for the British Museum were then exhibited. His next communication will be devoted to the animal remains.—*Lancet*, June 11, 1864.

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Dissolving Powers of the Pancreatic Juice.—M. Corvisart has shown that in animals the pancreatic juice has the power of dissolving albuminous foods without the assistance of the gastric juice or the bile; and now he has demonstrated the same thing in man. A hospital patient, in perfect health, having suddenly died from chloroform administered for the reduction of the femur, M. Corvisart removed the pancreas; and, with the prepared juice and ferment of it, operated on albuminous matters. He found that a large quantity of albumen and fibrin was rapidly digested with its assistance.—*Brit. Med. Jour.*, May 28, 1864.

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Obituary Record.—Died, at Pinkhill, near Edinburgh, June 17th, 1864, aged 52, James Miller, M. D., for 22 years the able professor of surgery in the University of Edinburgh, and author of a well known System of Surgery.

—— in Dublin in May, 1864, aged 49, Dr. Robert Johns, a distinguished obstetric practitioner of that city.